Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3376-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: NATIONAL UNION FIRE INSURANCE CO. Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "Continuing need."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $175.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Response not submitted.

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/17/2009	N/A	Out-of-Pocket expense – Office Visit	$175.00	$175.00
Total Due:				$175.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.
4. Neither party submitted EOBs or another form of denial for the office visit of 12/17/2009; nor did the Respondent submit a response to the request for Medical Fee Dispute Resolution.

Issues

1. Did the requestor submit receipt for the out of pocket expenses in dispute timely and in accordance with 28 Tex. Admin. Code §133.270?
2. Is the requestor entitled to reimbursement?

Findings

1. The dispute revolves around the repairs needed for the injured workers muscle stimulator and doctors' office visit to obtain an updated prescription for the muscle stimulator and chiropractic care. Review of the submitted documentation indicates the claimant contacted the adjustor on 08/14/2009; documentation supports that the adjustor indicates the "pt needs to go back to Dr. and get an updated Rx…ok." The injured worker went to the treating doctor on 12/17/2009 for an office visit to obtain a prescription for the use of the muscle stimulator. On 01/04/2010 the injured worker contacted the adjustor, Carolyn Jones and was told that she (adjustor) "wants to review Rx and note from Dr. faxing to 866-739-6983, said she will have an answer by Friday 1/8/10." The Requestor did submit LHL009 forms to the insurance carrier for an IRO review of the muscle stimulator and chiropractic care. These requests were considered not eligible for submission to the IRO.
2. As the injured employee's adjustor expressed to the injured employee that "pt needs to go back to Dr. and get an updated Rx" reimbursement, per 133.270(e) reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $175.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

	Marguerite Foster	July 30, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.